

IX. CONCLUSIONS/RECOMMENDATIONS

This report was authorized pursuant to LC § 5307.2, which was revised by SB 228 to require the AD of the DWC to “contract with an independent consulting firm...to perform an annual study of access to medical treatment for injured workers.” The primary goal of this annual survey is to “analyze whether there is adequate access to quality health care and products for injured workers and make recommendations to ensure continued access.” Furthermore, if the AD determines based on this study “that there is insufficient access to quality health care or products for injured workers,” the AD may make appropriate adjustments to medical and facilities fee schedules. Specifically, if the AD determines that “substantial access problems exist,” he or she may revise fee schedules by adopting fees “in excess of 120 percent of the applicable Medicare payment system fee for the applicable services or products.”

In response to the mandate for the study, the main objectives of this study were to:

1. Establish baseline information regarding the proportion of injured workers and physicians reporting access and/or quality problems in 2006;
2. Determine specific factors that promote or inhibit access to quality care;
3. Quantify the extent of such barriers;
4. Determine whether lack of access, if present, is substantial; and,
5. Recommend methods of ensuring continued access.

The injured worker, provider, and payer surveys conducted as part of this study were all fielded during 2006, two years after the reforms of 2003-2004. For the most part, it was impossible to obtain data related to access and quality prior to the implementation of WC reform. In the provider and payer surveys, it was only possible to obtain impressions about how WC access and quality have changed since 2004. However, this was not possible for the injured worker survey. Therefore, our results are most useful in establishing firm baseline data for determining the current state of California’s WC system from the perspective of three major stakeholders (Study Objective 1). These baseline data are

valuable for comparing California's current experience with previous WC studies, including those in California and in other states. These data should also prove valuable for monitoring changes in California's WC system over time. The findings presented in Sections VI, VII, and VIII of this report identify specific factors that promote or inhibit access to quality care and quantify the extent of such barriers (Objectives 2 and 3). Finally, our results suggest several important conclusions about whether access problems are substantial as well as other recommendations for maintaining access (Objectives 4 and 5), which are presented and discussed below.

1. The vast majority of injured workers reported they received care within 3 days of reporting their injury and had access to care within 15 miles or 30 minutes. The proportion of injured workers reporting other access problems was small. Based on these measures, access does not appear to be a major problem for the vast majority of injured workers.

The vast majority of injured workers (87%) reported they received initial treatment within 3 days of their injury. Time and distance to first and main providers were within requirements imposed on MPNs for the vast majority of injured workers. Most injured workers traveled 15 miles or less (86%) or 30 minutes or less (92%) to see their first provider. Most also traveled 15 miles or less (82%) or 30 minutes or less (89%) to see their main provider (i.e., the provider most involved in their care). High proportions of injured workers received recommendations for specialty care (31%), PT/OT (44%), and prescription drugs (65%). Finally, most injured workers reported they were able to access quality care for their injuries (83%). This percentage is slightly higher than the findings from a previous 1998 DWC study in which 77% of injured workers reported no trouble accessing care for their injuries.²

The proportion of injured workers reporting access problems was small. Only 3% report communication barriers with their main provider due to language discordance; while 2.4% did not see a specialist, 2.3% did not receive PT/OT, and 0.7% did not receive a

prescription when recommended because of authorization, transportation, or scheduling barriers. No comparable data exists from previous studies.

2. Most injured workers are satisfied with their overall care.

Our results show that 22% of injured workers were dissatisfied or highly dissatisfied overall with their care. Results from Pennsylvania's WC system, which has been collecting similar satisfaction data from injured workers annually since 2001, indicates a similar level of dissatisfaction (16.7% in 2004).³ Because our study did not collect data on injured workers prior to the implementation of reforms, we cannot directly evaluate changes in satisfaction between the pre- and post-reform periods. However, two large-scale studies of injured workers in California prior to the 2003-2004 reforms found that virtually the same percentage of injured workers (23.5%² and 20%⁴) were dissatisfied with their overall care. Therefore, we conclude that the satisfaction of injured workers has not changed as a result of recent reforms. Although there are many efforts to assess patient satisfaction among the general health population, comparisons of the satisfaction of injured workers and the general health population are difficult to perform, because most individuals in the general health population are not injured and patient satisfaction surveys generally do not provide data on satisfaction levels for injured and non-injured individuals separately.

3. The health outcomes of injured workers need further improvement.

Overall, 55% of injured workers have not fully recovered from their injury after one year, including 10% who report no improvement. Previous research by DWC on injured workers in California² showed a similar percentage of injured workers reporting no improvement, but a lower percentage reporting they were fully recovered (30% versus 45% in this study). Similarly, results from Washington state showed a lower rate of full recovery (28.1%).⁵ Both of these previous studies were conducted within a shorter time period after the original dates of injury — 8 months and 5 months, respectively — versus an average of about 15 months in this study. Therefore, a direct comparison of

rates of full recovery is not possible. Nevertheless, a majority of injured workers are not fully recovered after one year, suggesting that health outcomes can be further improved.

- 4. Injured workers with 10 or more visits for their injury represent slightly more than one quarter of injured workers and are more likely to report delays in time to first visit, dissatisfaction with their overall care, lack of improvement in their condition, and being out of work due to their injury. Because of the high level of resources associated with these injured workers, additional case management efforts may be needed to improve satisfaction, health and return-to-work outcomes for these workers.**

Injured workers with 10 or more visits — who represent 28% of injured workers — are 3 times more likely to report no improvement compared to those with less than 10 visits (19% versus 6%). Furthermore, injured workers with 10 or more visits were almost 7 times more likely to report they were not currently working due to their injury relative to other injured workers (27% versus 4%), suggesting that return-to-work outcomes could also be improved. These findings suggest that additional effort to manage the care of these more complicated cases may produce both lower utilization and improved outcomes, including return-to-work and overall satisfaction with care.

- 5. Important racial/ethnic differences in satisfaction and outcomes exist and need to be further investigated.**

Our results suggest that important differences in satisfaction and outcomes exist between racial/ethnic groups in California, with African-Americans experiencing worse outcomes relative to all other groups. Our findings do not adjust for possible differences in the mix of occupations, which may account for some of the differences observed in the data presented in this report. Nevertheless, the magnitude and statistical significance of the findings on disparities presented in this report suggest that further investigation of the underlying reasons for these disparities is clearly warranted.

6. Despite physician dissatisfaction with elements of WC reform, there do not appear to be access problems for most injured workers in the state, and physicians have not limited or given up their WC practices in large numbers.

The majority of providers (55%) reported that they disagreed with the statement that injured workers have adequate access to quality care, and 65% reported that access has declined since the 2003-2004 reforms. Furthermore, 56% of providers reported that quality of care had declined since the reforms, and 35% report that they are likely to quit WC entirely or to reduce their WC case loads. Chiropractors, acupuncturists, and orthopedic surgeons were particularly dissatisfied with the current system. The high level of dissatisfaction among acupuncturists and chiropractors is understandable in light of the implementation of the ACOEM guidelines and caps on visits, respectively, which most directly affect these provider groups. The dissatisfaction among orthopedic surgeons was primarily due to authorization/UR issues. Nevertheless, despite the reported intention of providers to quit treating WC patients altogether, our results suggest that a number of providers have increased their WC case loads. As a result, we do not find compelling evidence of access problems due to providers limiting or abandoning their WC case loads. In contrast, many of the comments reported primarily by acupuncturists and chiropractors in the open-ended portion of our survey suggested that they were dissatisfied that they were unable to get more WC cases referred to them.

7. Streamlining the authorization/UR process to improve access to care for injured workers seems warranted.

Providers most frequently reported that new regulations (31%) and authorization/UR issues (30%) were the most common reasons for the decline in their WC volume of cases. Furthermore, they most frequently reported authorization/UR issues (47%) as barriers to the provision of quality care. Therefore, mechanisms for improving the authorization/UR processes should be explored. Although only a small percentage of injured workers reported not receiving care because of authorization/UR denials or barriers, the high level of provider dissatisfaction with these processes may be a

relatively easy way to improve provider satisfaction and reduce the probability of providers leaving the WC system.

- 8. Providers frequently reported dissatisfaction with the OMFS, and those who were paid at the largest discounts below the fee schedule reported the largest declines in the volume of WC patients they treat. Increases in the fee schedule, or limits on the discounts insurers can pay below the fee schedule, may be warranted to ensure continued broad provider participation in the WC system.**

The most frequently cited reason for stopping participation in WC was payment or the fee schedule (46%). Providers paid 1% to 15% below the OMFS (65%) or more than 15% below the OMFS (66%) were more likely to report declines in WC volume since 2004 than those paid at or above the fee schedule (49%). When asked about the reasons for planned decreases, providers most frequently cited payment or fee schedule issues (47%). Comparing future plans for decreased volume of WC patients by provider payment levels showed that those who were paid more than 15% below the fee schedule were significantly more likely to report planned decreases or quitting the system entirely relative to providers who were paid at the fee schedule or higher (54% vs. 29%). Providers most often reported that improvements in the authorization/UR process (25%) and in the fee schedule (24%) would help them to continue treating WC patients. Furthermore, a recent study by WCRI shows that California on average pays about 21% above the Medicare fee schedule for physician services, whereas the median value across all states is 55%.⁶ For evaluation and management services (i.e., visits), California WC physicians receive on average 13% *below* the Medicare fee schedule.⁶ Therefore, increases in the fee schedule, at least for some services, or limits on the discounts insurers can pay below the fee schedule, may be warranted to ensure continued broad provider participation in the WC system.